

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010889	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/21/2020
NAME OF PROVIDER OR SUPPLIER WYNDMOOR OF PORTAGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3444 SWANSON RD PORTAGE, IN 46368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00319620.</p> <p>Complaint IN00319620 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: February 21, 2020</p> <p>Facility number: 010889</p> <p>Residential Census: 39</p> <p>Wyndmoor of Portage was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00319620.</p> <p>Quality review completed on 2/21/20.</p>	R 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE